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# Utility and Equity in Public Health



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Abstract

Background: Many public health practitioners and organisations view themselves as engaged in the promotion or achievement of equity. However, discussions around public health frequently assume that practitioners and policy-makers take a utilitarian approach to this work.

Methodology: I argue that public health is better understood as a social justice endeavor. I begin by presenting the utility view of public health, and then discuss the equity view. This is a theoretical argument, which should help public health to justify interventions for communicable and non-communicable diseases equally, and which contributes to breaking down the 'old/new' public health divide.

Results: This argument captures practitioners' views of the work they are engaged in, and allows for the moral and policy justification of important interventions in communicable and non-communicable diseases. Systemic interventions are necessary to remedy high rates of disease among certain groups and, generally, to improve the health of entire populations.

Conclusions: By viewing diseases as partly the result of failures of health protective systems in society, public health may justify interventions in communicable and non-communicable diseases equally. Public health holds a duty to improve the health of the worst-off in society; by prioritizing this group, the health of the whole community may improve.

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## The Utilitarian View

The assumption that public health is utilitarian by nature appears in certain policy and ethics literature. In their discussion about the development of genetic technologies, Buchanan, Brock, Daniels, and Wikler take this perspective.[1] In presenting contrasting models upon which to view these technologies, the authors discuss what they term 'the public health model,' which stresses the production of benefits and the avoidance of harms among groups. Such a model, they argue, "uncritically assumes that the appropriate mode of evaluating options is some form of cost-benefit calculation."[1] They elaborate, "to the extent that the public health model even recognizes an ethical dimension to decisions about the application of scientific knowledge or technology, it tends to assume that sound ethical reasoning is exclusively consequentialist (or utilitarian) in nature."[1] They write that a public health model would assume that the rightness of a policy or action would depend solely on whether it produced more benefits over harms, on balance.

Similarly, Bayer and Fairchild argue that utilitarian justifications underlie many public health activities. They write that "at the core of public health practice is the charge to protect the common good, to intervene for such ends even in the face of uncertainty,"[2] and that public health is "animated by a broad utilitarianism that seeks to maximise communal well-being."[2] When public health limits the behaviour of some for the protection of the many, it is operating on the welfare-maximising principles of utilitarianism. So, quoting Robert Goodin, they write that public health is able to simply prohibit things, and that this "is justified most standardly by recourse to utilitarian calculations."[3] Further, in a recent paper arguing in favour of the use of fearful and stigmatising messages in health promotion campaigns, Bayer and Fairchild write that they were struck by "the attention devoted to the question of efficacy, [upon which] a strategic

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emphasis was crucial, given the centrality of utilitarian considerations to public health policy makers."[4]

While the authors presented here do not themselves take a straightforwardly utilitarian approach to public health, these comments establish that there is a common view among some in public health, or at least, there is an assumption about the view commonly held by practitioners or policy-makers in public health, that takes utilitarianism as standard. In what follows, I will argue that not only do practitioners and (many) policy-makers not consider public health to be centrally utilitarian, we have good reason to prefer a model of public health that assumes a focus on equity and social justice.

## The Equity View

Contrary to the way public health is conceptualised in the passages above, public health policy-makers, organisations, and practitioners (physicians, nurses, and other allied health professionals) often describe themselves as engaged in endeavours focussed on equity. For example, in Public Health England's (PHE) strategic remit and priorities letter for 2017-18, Member of Parliament Nicola Blackwood states that PHE "fulfils the Secretary of State for Health's statutory duties to protect health and address health inequalities..."[5] Likewise, the Nuffield Council on Bioethics writes that public health involves "the collective efforts of all parts of society…, [and] should contribute to generating and supporting measures that improve the health of all. The role of the government is to provide certain key services that… operate in a way that is compatible with promoting population health and reducing inequalities."[6] Even when public health practitioners have philosophically unclear conceptions of health equity, many describe their work as primarily concerned with achieving this.[7] Though a matter of some debate

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(which will be explored below), there is general agreement among academics, practitioners, and international non-governmental organisations, like the World Health Organisation, that concern for equity among members of a community is at least a legitimate modifier or constraint upon the ways in which the goals of public health may be sought.

Within these discussions, the meaning of 'health equity' and how public health should aim to achieve it has been a topic of significant debate.[7] Some of the main points of argument focus around the notion that 'equity' is a term relating to the justness of distributions, and achieving equity of health states is complicated due to heritable and accidental differences in human functioning.[7] However, public health is able to use epidemiological research, observing the overall rates of disease in groups, rather than observing individual-level instances of illness or other differences in general health states, to measure whether and by how much certain disease factors disproportionately affect groups in society.[12] This, in turn, allows the redress of inequities resulting from systemic and distributional failures that lead to higher rates of disease among particular groups.[13-15] Thus, I argue that public health ought to take the achievement of equity as a central goal, rather than as a limiting factor upon means of achieving certain aims, or the aims themselves. Public health has the ability and the obligation to address disadvantage, by improving capacities and avoiding further inequities, in order to achieve and maintain gains in the health of the entire community.

The 'publicness' of public health can be captured via accounts of human flourishing and capabilities.[8] Members of a community have collective interests in goods and harms, many of which directly and indirectly impact individual well-being, and public health is one of a suite of government agencies responsible for providing access to and material requirements for the development of fundamental human capacities and functionings.[8] Dawson provides examples of

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a number of different kinds of interests – congruent, convergent, and common – related to health, in which people require certain public conditions to be true to achieve their private goals.[8] So, herd immunity through vaccination (convergent), water treatment and sewage systems (congruent), and low rates of HIV in the population (common), are all interests that people share on the basis that these background conditions allow each person to be better able to obtain their own goals. Public health is charged with securing these background systems-level conditions, among others, that permit the flourishing of the population as a whole, and which provide the basis for individual levels of health-related capabilities.[9,10]

Due to the unique positioning of public health to identify and address disadvantage in a society, Bruce Jennings argues that public health is concerned with a 'sensibility of place.'[16] Jennings means that public health should enable people to dwell in an environment conducive to health and to justice. Public health plays an important role in setting up conditions conducive to and likely to achieve justice, he argues. This ought to be one of the goals of public health interventions, insofar as each person requires a certain level of health in order to achieve other aims. As Amartya Sen said, "health is freedom enhancing, by expanding our actual capability to do what we may have reason to do."[17] Deeply disadvantaged people, who lack the basic opportunities of health, functional education, gainful employment, or economic and social security experience "varieties of unfreedom."[18] Personal freedom is inextricably linked to the flourishing of others, and so mutuality of concern and respect, or solidarity in matters affecting health, are the kind of common interest best supported by collective interventions.[10,16,18]

Reid argues that it is a normatively significant fact about our world that deficits in one or more areas of the social determinants of health may lead to deficits in other areas.[15] This creates what Wolff and de-Shalit call 'clusters' of interconnected sources of disadvantage.[19] When

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conditions or factors for disease are correlated to states of disadvantage in a society in which some groups suffer directly as a result while others do not, distributive justice would demand that the society take action to remedy these discrepancies, and, as Wolff and de-Shalit say, 'decluster' these disadvantages.[19] Public health, in a society with the means to do so, ought to endeavour to close the gap between social groups by improving conditions for the worst-off, so that disadvantages do not cluster around specific groups but are more evenly shared among groups. Understanding how inequalities cluster helps us to identify the disadvantages that public health most needs to address.[15] Responsibility for doing this lies partly with public health agencies, insofar as they are vested with the democratically-derived authority and power of government, as well as with other government branches, like education and housing. This is especially the case when social conditions would resist individual remediation, and in which people are facing deep disadvantage. As disadvantageous conditions for some lead to reductions in flourishing for all, we have an additional collective interest in reducing inequities.

## The Need for Collective Action

Public health's ends can only be achieved through collective action. Systemic interventions, rather than individual-level actions, are necessary to remedy high rates of communicable and non-communicable disease and, more generally, to improve the health of entire populations. In this section, I discuss the trend toward individual interventions that public health agencies seem to have joined, even while most practitioners recognise that these do not address the causes of poor health. In the ethics of public health, a distinction between 'old' and 'new' public health has been gaining attention.[11,12,20-22] In the distinction created by contrasting 'old' and 'new' public health, the term and 'new' is often used to label a perceived shift in the aims of public health

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activity. This shift takes public health away from the 'traditional' work that would typically include things like infectious disease control, sanitation, and a focus on disease-vectors, toward 'non-traditional' public health work, with a focus on personal health risk, lifestyle factors, and their connection to individual behaviours.[11,20,21] For example, critics of 'new' public health work characterise it as inappropriately focussing on the so-called modifiable risk factors for non-communicable diseases.[23] A focus on smoking, alcohol, eating habits, and physical activity – a collection of alleged lifestyle choices – has developed, with increasing focus on individual behaviours and responsibilities.

The perception that public health's attention has shifted toward matters of 'individual' health behaviours coincides with a shift in policy developments that highlights individualism and a utilitarian approach to health policy. The Marmot Review Working Committee has termed this 'lifestyle drift.'[24] The Committee writes that lifestyle drift is "the tendency for policy initiatives on tackling health inequalities to start off with a broad recognition of the need to take action on the wider social determinants of health (upstream), but which, in the course of implementation, drift downstream to focus largely on individual lifestyle factors."[24] In tandem with the shift towards the 'new' public health, lifestyle drift has taken place over a number of years. It coincides with the current low-intervention political climate in many of today's advanced democracies, reflecting long-standing anxieties about personal liberty, where worries about (unjustified) interference with individual choices about self-regarding health behaviours have been paramount.[25-27]

Some authors employing the old/new public health distinction take the position that interventions should be restricted to 'old' or traditional public health concerns like safe water, sanitation, infectious diseases, and food hygeine.[11] Some of the arguments against 'new' public



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health activities are motivated by worries about the government overstepping its boundaries, and interfering inappropriately with people's liberty.[11,21,28-30] The foundation of these arguments is that 'old' public health interventions, and the impact these had on individual liberty, were more appropriate and/or legitimate for addressing communicable diseases. Interfering with liberty because of communicable disease can be justified on a utilitarian calculus by the balance of potential harms to others, or by failures of infrastructure that provides protection from such diseases. This is contrasted with 'new' public health interventions, which, critics argue, address individual choices that are not communicable nor caused by traditional disease vectors. This removes the ability to justify interventions based on harms to others, leaving each person to make their own cost-benefit decisions. These are, therefore, less appropriate or legitimate targets of public health intervention.

Rothstein, for example, argues that, unlike with 'old' public health measures, where public health can exercise its police powers (like quarantine) to protect people with some level of legitimacy, people's failures to undertake 'new' public health measures do not put the health of other people at risk, and so may not justify public health interventions that restrict people's liberty.[22] This utilitarian framing of public health interventions, which contrasts health risks with the liberty of community members when securing a collective interest, at the least inappropriately prioritizes individual liberty over other values,[26] and at worst denies that there are systemic contributors to non-communicable diseases that would be good targets for public health. Rothstein's view, and those like it, assumes that threats to liberty are more important than threats to health that might come from social conditions. O'Neill observes that such an obsessive focus on individual liberty may result in a negative impact on the health of the public.[8]

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Additionally, if we give equity (and possibly other values) as much weight as individual liberty, we can see that the claim that there is a distinction between 'old' and 'new' public health activities is a false dichotomy. If we set liberty aside for a moment, and consider a 'traditional' public health concern, such as sanitation, from the perspective of promoting equity, we may see that it shares some commonalities with non-communicable disease. To illustrate, where disadvantage (poverty) is linked to a disease (cholera) resulting from lack of access to an important resource (clean water), then providing a systems-level solution to address disadvantage (a sewage system and clean water source in poor neighbourhoods) instead of individual interventions (boil-water advisories or cholera-awareness campaigns) more effectively achieves collective well-being, though it may represent a greater infringement upon liberty (the introduction of rules and regulations). 'Traditional' public health activity is concerned with securing equity of health-related functioning by promoting and protecting collective well-being at some cost to liberty, just like 'new' public health interventions. Public health's involvement in supplying sewage and clean water is not solely dependent upon the communicability or mode of action of a disease. Rather, it is dependent upon the community-based nature of the issue and the impact it has on people; sanitation cannot be achieved by individuals, but the lack of it has devastating impacts on individual and community health, thus it must be undertaken collectively.

The WHO consistently takes the view that its modifiable risk factors for disease require collective action, because these cannot be addressed solely by individuals, and the systems failures that give rise to them are damaging to the community as a whole. The framing of non-communicable diseases with modifiable risk factors as 'lifestyle' diseases, because of an apparent link to individual choice, however, is dependent upon viewing something like a population rate of obesity as non-systemic, and placing it opposite an 'old' public health issue,

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like sanitation. In this vein, Anomaly argues that obesity is not necessarily a public health problem, even though reducing obesity may be a public good.[28] He argues that fatness is not contagious and does not spread via typical disease vectors. Obesity, he says, is neither unpredictable nor indiscriminate. The use of the word 'epidemic' or 'public health crisis,' he argues, are applied hyperbolically "to gain sympathy for politically controversial goals."[28] In arguing that we ought to give individual liberty priority, Anomaly uses the behaviour of a disease, such as its potential for contagion, to determine its relevance to public health. Obesity is not contagious, so, Anomaly writes, public health does not have the responsibility nor the authority to overstep individual liberty to act on it, though the public may benefit from such action.[28]

Anomaly's view overlooks important features of 'lifestyle diseases' that may qualify them as public health problems. For example, contributors to obesity are systemic, and have roots in unpredictable and indiscriminate inequities that have measurable impacts on health. Population rates of obesity have been linked to a socio-economic gradient, and result from a complex network of economic and educational disadvantages, in combination with the systems of food production, transportation, advertising, and provision, as well as changes in the working and built environments, among other things.[13,14,31-34] Thus, obesity is partly the result of systemic and distributional failures like other public health problems. In fact, mounting evidence suggests that obesity cannot be addressed individually nor via individual choices alone, but must be addressed at multiple levels of social systems.[8,17,33] When the causes of behaviours that contribute to a disease are not just the result of an individual's choice, but are constrained by a variety of conditions outside of individual control, then it may not be appropriate to attribute responsibility for the consequences of "choices" to individuals in any meaningful sense.[8,10]

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Additionally, people with obesity tend to be subject to multiple sources of political and social oppression that remain concealed by the view that it results from individual behaviour, such as by framing eating behaviours or physical activity in terms of 'modifiable' risk factors for disease.[13,27] We now have evidence that obese people experience marginalisation in the workforce, features of cultural imperialism such as stereotyping, and the distortion of responsibility that simultaneously blames them individually for having obesity and removes their power to explain or present reasons.[35-37] Individual-level public health interventions contribute to this distortion of responsibility when they address the public *qua* separate individuals, rather than as an interconnected group. This happens when public health agencies focus on attempting to motivate individuals to change their choices. This places the responsibility for change on the individual themselves, and obscures the constraints upon their choices.

## Discussion

Main findings of this study: Meeting public health goals requires collective action, and systems-level interventions (rather than individual-level interventions) are coherent with the expressed values of public health and its practitioners. Understanding public health as centrally motivated by concerns for social justice permit policy-makers and practitioners to refocus their interventions, and to justify initiatives for non-communicable diseases that too strong a focus on individual liberty may reject. Initiating and justifying projects from the perspective of equity may assist public health in fending off 'nanny state'-type objections to various interventions.

What is already known on this topic: This issue has received attention across academic, government, and non-governmental bodies over the past decade. This paper joins on-going





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discussions about the nature of public health's work, and the appropriate responses to communicable and non-communicable diseases.

What this study adds: This paper addresses an important issue in public health and makes a new argument for the need to approach public health from a collective, equity-focused position.

Limitations of this study: There is much academic, governmental, and non-governmental work in global health law and policy that this paper does not reference directly, but which is relevant and connected to the topic. For reasons of space, the paper is approaching only a small slice of the ethics and policy literature.

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References

1. Buchanan, A., Brock, D., Daniels, N., Wikler, D. *From Chance to Choice: Genetics and Justice*. Cambridge, UK: Cambridge University Press, 2000.

2. Bayer, R., Fairchild, A. The genesis of public health ethics. *Bioethics* 2004, 18(6): 472-492.

3. Goodin, R.E. *No Smoking: The Ethical Issues*. Chicago, USA: The University of Chicago Press, 1989.

4. Bayer, R., Fairchild, A. Means, ends and the ethics of fear-based public health campaigns. *Journal of Medical Ethics* 2016, 42: 391-396.

5. Blackwood, N. *Public Health England Strategic Remit and Priorities*. Letter to Duncan Selbie, Chief Executive. 12 April 2017. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/609071/PHE_remit_1718.pdf.

6. Nuffield Council on Bioethics. Chapter 1: Introduction. In *Public Health: Ethical issues.* London, UK: Nuffield Council on Bioethics, 2014. Available at http://nuffieldbioethics.org/wp-content/uploads/2014/07/Public-health-ethical-issues.pdf.

7. Smith, M.J. Health equity in public health: Clarifying our commitment. *Public Health Ethics* 2015, 8(2): 173-184.

8. Dawson, A. Resetting the parameters: public health as the foundation for public health ethics. In A. Dawson (Ed), *Public Health Ethics: Key concepts and issues in policy and practice*. Cambridge, UK: Cambridge University Press, 2011, 1-19.

9. Kass, N. An ethics framework for public health. *American Journal of Public Health* 2011, 91(11): 1776-1782.

10. Powers, M., Faden, R. *Social justice: The moral foundations of public health and health policy* (1st ed.). UK: Oxford University Press, 2006.

11. Epstein, R.A. Let the Shoemaker Stick to His Last: A Defense of the "Old" Public Health. *Perspectives in Biology and Medicine* 2003, 46(3): S138-S159.

12. Verweij, M., Dawson, A. The meaning of 'public' in 'public health'. In A. Dawson & M. Verweij (Eds.), *Ethics, Prevention, and Public Health*. Oxford, UK: Oxford University Press, 2007, 13-29.

13. Chaufan, C., Yeh, J., Ross, L., Fox, P. You can't walk or bike yourself out of the health effects of poverty: active school transport, child obesity, and blind spots in the public health literature. *Critical Public Health* 2015, 25(1): 32-47.

14. Friel, S., Hattersley, L., Ford, L., O'Rourke, K. Addressing inequities in healthy eating. *Health Promotion International* 2015, 30(S2): ii88.

For Peer Review

15. Reid, L. Does population health have an intrinsically distributional dimension? *Public Health Ethics* 2016, 9(1): 24-36.

16. Jennings, B. Relational liberty revisited: Membership, solidarity and a public health ethics of place. *Public Health Ethics* 2015, 8(1): 7-17.

17. Womack, C. Public health and obesity: When a pound of prevention really is worth an ounce of cure. *Public Health Ethics* 2012, 5(3): 222-228.

18. Sen, A. *Development as freedom* (1st ed.). New York: Alfred A. Knopf, 1999.

19. Wolff, J., de-Shalit, A. *Disadvantage.* Oxford, UK: Oxford University Press, 2007.

20. Bell, K., McNaughton, D., Salmon, A. (Eds.). *Alcohol, tobacco, and obesity: Morality, mortality and the new public health*. London, UK: Routledge, 2011.

21. Pratt, K. The limits of anti-obesity public health paternalism: Another view. *Connecticut Law Review* 2014, 46(July): 1903-1936;

22. Rothstein, M.A. Rethinking the meaning of public health. *Journal of Law, Medicine & Ethics* 2002, 30: 144-149.

23. World Health Organisation. *Noncommunicable diseases fact sheet*. Geneva: World Health Organisation 2015.

24. Hunter, D.J., Popay, J., Tannahill, C., Whitehead, M., Elson, T. *Learning Lessons from the Past: Shaping a Different Future*. Marmot Review Working Committee 3 Cross-cutting sub-group report, 2009.

25. Owens, J., Cribb, A. Beyond choice and individualism: Understanding autonomy for public health ethics. *Public Health Ethics* 2013, 6(3): 262-271.

26. Wilson, J., Dawson, A. Giving liberty its due, but no more: Trans fats, liberty, and public health. *American Journal of Bioethics* 2010, 10(3), 35-37;

27. Schrecker, T., Bambra, C. *How Politics Makes us Sick: Neoliberal Epidemics*. Basingstoke, UK: Palgrave Macmillan, 2015.

28. Anomaly, J. Is obesity a public health problem? *Public Health Ethics* 2012, 5(3): 216-221.

29. Moore, M., Yeatman, H., Davey, R. Which nanny - the state or industry? wowsers, teetotallers and the fun police in public health advocacy. *Public Health* 2015, 129: 1030-1037.

30. Wiley, L. F., Berman, M. L., Blanke, D. Who's your nanny? choice, paternalism and public health in the age of personal responsibility. *Journal of Law, Medicine & Ethics* Spring 2013,

For Peer Review

(Supplement: 2012 public health law conference: practical approaches to critical challenges): 88-91.

31. Farrell, L. C., Warin, M. J., Moore, V. M., Street, J. M. Socio-economic divergence in public opinions about preventive obesity regulations: Is the purpose to 'make some things cheaper, more affordable' or to 'help them get over their own ignorance'? *Social Science & Medicine* 2016, 154: 1-8.

32. Green, M.A., Strong, M., Razak, F., Subramanian, S.V., Relton, C., Bissell P. Who are the obese? A cluster analysis exploring subgroups of the obese. *Journal of Public Health* 2015, 38(2), 258-264.

33. Standing Senate Committee on Social Affairs, Science and Technology. *Obesity in Canada: A whole-of-society approach for a healthier Canada*. Ottawa, Canada: Senate Canada, 2016.

34. Warin, M., Zivkovic, T., Moore, V., Ward, P.R., Jones, M. Short horizons and obesity futures: Disjunctures between public health interventions and everyday temporalities. *Social Science & Medicine* 2015, 128: 309-315.

35. Young, I. M. *Justice and the politics of difference*. Princeton, NJ: Princeton University Press, 1990.

36. Benson, P. Feeling crazy: Self-worth and the social character of responsibility. In C. Mackenzie, & N. Stoljar (Eds.), *Relational autonomy: Feminist perspectives on autonomy, agency, and the social self.* Oxford, UK: Oxford University Press, 2000, 72-93.

37. MacKay, K.L. A feminist analysis of anti-obesity campaigns: Manipulation, oppression, and autonomy. *International Journal of Feminist Approaches to Bioethics* Forthcoming.

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